



**Commonwealth of Massachusetts**  
**Executive Office of Health and Human Services**  
**Department of Public Health**  
**Division of Health Care Quality**  
**10 West Street Boston, MA 02111-1212**  
**Telephone 617-753-8000 Fax 617-753-8095**

Application for Certificate of Registration to Conduct Human Embryonic Stem Cell Research in Accordance with M.G.L. c. 111L

**Please be sure to:**

- Complete the application.
- Enclose a check or money order for \$200 made payable to the "Commonwealth of Massachusetts".
- Have the Institution's President, Chief Executive Officer, or designee sign and date the application.
- Provide documentation demonstrating that the Institution has an Institutional Review Board. Documentation may include, but is not limited to, a copy of a contract between the Institution and either a private or public institutional review board for review of the Institution's research to the extent required by M.G.L. c.111L, s.3(b), or a copy of the Institution's Federalwide Assurance (OMB No. 0990-0278).
- Mail to the address above.

**Please note:**

- Certificates of Registration expire three (3) years from the date of issuance.
- Any change to information on this application must be submitted within 30 days of such change. Use this application and select "Amended Information".
- Incomplete applications will be returned and will cause a delay in the Institution's receipt of a DPH Certificate of Registration.

Application Type (Please select one):

☐ Initial Application

☐ Renewal

☐ Amended Information

In the boxes below enter the requested information

**1) Applicant: (Institution name):**

**2) Applicant Business Address:** (An application with a P.O. Box number and without a street address cannot be accepted)

Street 1 \_\_\_\_\_

Street 2 \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**3) Contact Information:**

President/C.E.O \_\_\_\_\_

Telephone # \_\_\_\_\_

Email Address \_\_\_\_\_

**4) Federal Tax ID#** (Required by M.G.L. c. 30A, s 13A):

**5) Name of IRB:**

As the individual with legal authority to obligate this institution, I certify that the information disclosed on this application is true and correct. If any of the disclosed information changes, I agree to notify the department in writing by submitting an amended application form within 30 days of any change. I further certify that the applicant will comply with the laws of the Commonwealth of Massachusetts, including M.G.L. c.111L and M.G.L. c.62C, s.49A and all applicable rules and regulations. To the best of my knowledge, the applicant has filed all state tax returns and paid all state taxes required by law.

Signed under pains and penalties of perjury.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DPH Use Only**  
Certificate No.

Issued on:

Expires on: